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ABSTRACT

The goals of the 1988 Colorado Health Education Survey were: (1) to document the status of health education in Colorado schools by surveying all school districts in the state as well as by sampling teachers; and (2) to make recommendations based upon study findings available for consideration by the Colorado Department of Education. Part 1, the District Survey, was sent to designated health education contacts or the superintendent in all of Colorado's 176 school districts. The purpose of this part of the survey was to obtain information about school districts' policies, curriculum, health-related programs, health education funding, and community involvement. Part 2, the Teacher Survey, was sent to 1,000 teachers statewide to learn about classroom instruction and resources. Data from the survey are displayed on charts and graphs, and the two surveys are appended. The surveys revealed that: teachers need additional educational preparation and inservice training; districts need to develop written health education policies; and programs which supplement and support health education instructional goals are important. (JD)

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SCHOOL HEALTH EDUCATION

IN COLORADO

1988 Colorado School Health Education Survey

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May, 1989

SCHOOL HEALTH EDUCATION

IN COLORADO

1988 Colorado School Health Education Survey

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This survey was conducted by the Colorado Department of Education to learn the status of health education in Colorado. The results reflect the practices, priorities, and needs of educators across the state. **The Department appreciates the support and assistance of The Colorado Trust in funding this project.**

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EXECUTIVE SUMMARY

Survey Purpose and Design

The goals of the 1988 Colorado School Health Education Survey were two-fold. The first was to document the status of health education in Colorado schools by surveying all school districts in the state as well as by sampling teachers. The second was to make recommendations based upon study findings available for consideration by the Colorado Department of Education. The survey consisted of two parts.

Part One, the District Survey, was sent to designated health education contacts or the Superintendent in all of Colorado's 176 school districts. The purpose of this part of the survey was to obtain information about school districts' policies, curricula, health-related programs, health education funding, and community involvement. A copy of Part One, the District Survey, is included as Appendix A. Of the districts, 170 have health education contacts to whom the survey was sent; in the six districts without such a contact, surveys were sent to the Superintendents. Ninety-six (55%) of the 176 district contacts responded.

Part Two, the Teacher Survey, was sent to 1,000 teachers statewide to learn about classroom instruction and resources. The purpose of this part of the survey was to ask those persons actually providing instruction to address questions related to instruction time, health content and skills being taught, inservice needs and instructional resources. Part Two is included in Appendix B. Of the 1,000 teachers surveyed, 500 were randomly-selected elementary teachers. The other 500 surveys were sent to health instructors in junior high/middle school or high school. Seven hundred teachers, representing 131 districts (74%), responded to this survey.

Major Findings

- **Health education is provided and administered by educators who have most of their educational preparation in academic areas other than health education.** Eighty percent of the teacher respondents are not certified in health education. On the average, health education instructors have earned just over one-half semester credit hour in health education in the last three years. Likewise, 88% of the district contact respondents have their professional preparation in other areas. A majority of teachers and administrators who responded to the survey are certified in elementary education or health and physical education.

- **The majority of school districts do not have written health education policies though two-thirds of districts have adopted a formal health education curriculum.** Of the 96 school districts responding to the survey, 41% of the elementary, 51% of the junior high/middle, and 40% of the high school contacts report that they have a written policy regarding health education. Sixty-seven percent of all responding school districts report having a formal health education curriculum.

- **Although community involvement and a needs assessment are recognized as major factors when adopting a health education curriculum, few of the responding districts report that they actively involve parents.** Forty-two of the 96 districts responding (44%) stated that they had an active community/school health education committee. Of the districts that report having an active community/school committee, membership is reported to consist primarily of school personnel. Less than one in three districts report having ever surveyed parents and community members about what they would like in a school health education program.

- **Although a variety of health education resources are available to educators, teachers are making little use of them.** Most educators report that they rely on resources that are within close proximity or that have been developed by their own school district. Teachers are not aware or choose not to use a variety of free or inexpensive resources available to them. This may be due to a lack of identification and public knowledge regarding the who, what, and where of possible speakers, materials and services available.

- **Health education should begin in the elementary grades and span all grade levels; most health education is provided as a seperate course of study at the high school level.** Teachers report providing an average of 30 hours instruction per year at grade levels one through three, 39 hours per year at grade levels four through five, 58 hours per year at grade levels seven through nine, and 73 hours per year at grade levels 10 through 12.

- **District contacts and teachers support additional inservice training.** Regardless of school district setting, the need for inservice training is reportedly critical in the areas of mental health, AIDS education, substance abuse, violence/abuse and family life/human sexuality. These inservice needs relate to already identified statewide health problems.

Recommendations

Recommendation 1: Educators who provide health instruction should take a minimum of two credits in health education as part of the teacher recertification requirement. In addition, in-depth inservice training should be provided for educators who teach mental health, AIDS education, abuse and violence, coping skills, alcohol and other drug abuse, decision-making, family life/human sexuality, refusal skills, and communication skills.

In a field which is changing as rapidly as health education, teachers must have opportunities to enhance their knowledge and skills through inservice training; to attend such training, they must also have administrative support for release time and substitute pay. State agencies and organizations must continue to provide inservice training opportunities at affordable costs, and districts must continue to look for sources of revenue to fund these training opportunities.

In addition, districts should choose curricular materials that include inservice training for teachers. A School Health Education Evaluation (*Journal of School Health*, October, 1985), revealed that teachers who complete inservice training use a higher percentage of the health curriculum than those with partial or no training. The same study noted that student knowledge, attitudes and practice scores correlate positively with the amount of inservice training provided to their teachers.

Recommendation 2: All school districts should have written health education policies to guide curriculum development and content. The development of these policies ought to include a process of community needs assessment and active parental involvement. Without policies health instruction may not reflect community values. The success of health instruction can depend on the statement of goals and parameters in the policy.

Recommendation 3: Significantly more health education instruction is needed at the elementary level. Although two-thirds of the responding districts require health education at almost all grade levels, little instruction is taking place at the elementary level. Health education research, particularly the School Health Education Evaluation , SHEE study, provides evidence that such education works best when the foundations of basic health knowledge are built in the beginning grades — rather than when instruction begins with categorical health problems in later grades. Districts need programs that cover a variety of health skills and health content during the elementary years. Coping skills, AIDS education, consumer health, family life/human sexuality education, mental health and family violence/child abuse prevention need to be taught in the primary grades using age appropriate materials.

Recommendation 4: Programs which supplement and support health education instructional goals are important. Such programs include peer counseling, onsite health/mental health services, parent education programs, wellness programs for staff and student assistance programs. While formalized health education instruction is essential, enhancing the school environment through a variety of extra-curricular programs will create a more positive climate and thus a healthier community.

Recommendation 5: An active community/school health education committee can promote health education. Districts benefit from meaningful involvement of parents and community members in health education advisory groups. Health education deals with sensitive topics such as AIDS, human sexuality, substance abuse, and other issues affecting families. Districts must actively seek out and involve families in planning, implementing, and evaluating school health programs. Broad community involvement is desirable, since teen pregnancy, substance abuse, suicide, violence and unintentional injuries adversely affect the entire community both economically and socially; community representation ideally includes business, labor, religious groups and civic organizations.

Law enforcement representatives can be actively involved in health education advisory groups, and utilized as an instructional resource by teachers. Law officers were identified as a major resource in drug and alcohol prevention education. Representatives from the field of law enforcement need to be included as members of advisory groups.

CHAPTER ONE: DISTRICT RESPONSES

Part One of the Survey

1. District Response Rate

Ninety-six (55%) of the 176 district contacts responded to Part One of the survey. These findings are to be interpreted with caution, since there is no way of knowing whether or not responding districts are representative of all school districts. Neither can the findings be extended from the set of respondents to all school districts. For example, since two-thirds of the 55% of the districts that responded indicated that they have a formal health education curriculum, one might be tempted to assert that 67% of all districts have such curriculum. This would not be a legitimate assertion. The findings do allow us to state with confidence that 36% (that is, two-thirds of 55% percent) of all school districts in Colorado report having a formal health education curriculum at some level.

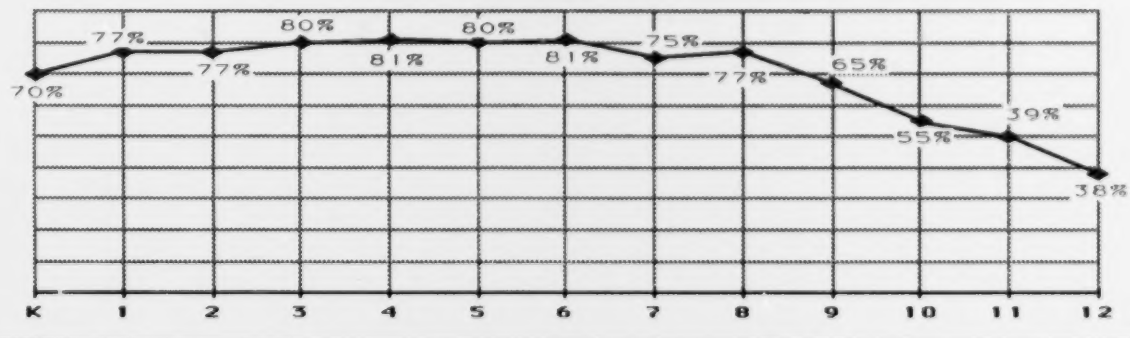
2. Districts' Formal Health Education Curriculum

Sixty-seven percent of the 96 school districts responding to this survey indicated that they have a formal health education curriculum. Such a curriculum is defined here as a written plan containing detailed information about grade level offerings and other suggestions for health education instruction in the school district. It describes the overall philosophy, goals, objectives, scope and sequence of the health education program.

As Figure 1 indicates, formal curriculum tends to occur more often in the primary grades. A formal curriculum becomes less evident in the intermediate/junior high years, and drops significantly in high school. It is interesting to note that the intermediate/junior high years, when districts report doing the most health education teaching, are not the years when districts report the highest levels of formal health education curriculum.

Figure 1

The Distribution of Formal Health Education Curriculum by Grade Level



In addition, although a formal curriculum appears to be in place most often in the primary grades, the amount of instruction by content and skill areas in those grades is significantly less than the amount of instruction provided to older students. It is also worth noting that districts having a formal curriculum in place may or may not have a health education policy. Indeed, among respondents, whether or not there are adopted health education policies, the presence of a formal district health education curriculum and the amount of health education instruction are not significantly correlated.

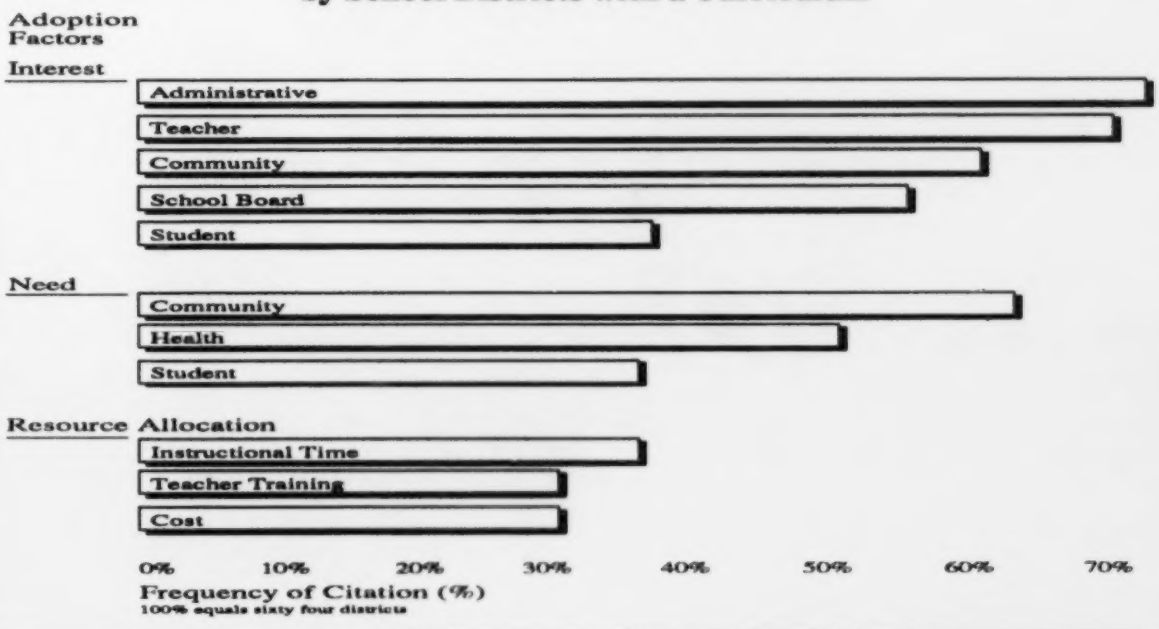
3. Factors Influencing Curriculum Adoption

Those who reported having a formal health education curriculum were asked to choose from among a set of factors that influenced their adoption of such a curriculum. As many factors as were thought to be involved in their decision could be selected. The results are shown in Figure 2. Administrative and teacher interest was reported as more important than student interest or health needs at a ratio of about 2 to 1, and was slightly more important than community needs or interest. In fact, interest was by far the most important factor, with resource allocation least important.

Not surprisingly, rural communities with a relatively small student population (fewer than 600 students) were more than twice as likely as larger districts to list cost as a major factor affecting the adoption of curriculum. For the larger districts, cost was not reported as a major influencing factor.

Figure 2

The Frequency of Citation of Health Education Curriculum Adoption Factors by School Districts with a Curriculum



4. District-Adopted Curricular Materials

Two instructional packages were reported as being adopted by a significant number of respondent Colorado school districts. One is *Teenage Health Teaching Modules* (a 7th -12th grade curriculum), which has been adopted by 70% of districts responding to the survey. This program is currently being evaluated for national validation. A second package, *Growing Healthy* (a kindergarten-7th grade curriculum), was listed by 49% of the respondents; this program is a nationally-validated comprehensive health education program. Both are disseminated by the Rocky Mountain Center for Health Promotion and Education.

District contacts were asked which programs require inservice training, and at what grade level the programs are being used. Figure 3 lists their responses. An examination of this figure reveals that none of the districts report implementing a health education curriculum prior to 1980. It is worth noting almost all of the district adopted curricula materials require inservice training .

Figure 3

PERCENT OF DISTRICTS ADOPTING CURRICULAR MATERIALS/INSTRUCTIONAL PACKAGES, GRADE LEVEL IMPLEMENTATION, AND INSERVICE TRAINING REQUIREMENTS

# of Districts Responding to Item	Percent of Districts Using Program	Curricular Material	Grades in which Used	Earliest Year Implemented	Inservice Training Required
53	70%	TEENAGE HEALTH TEACHING MODULES	7-12	1980	YES
37	49%	GROWING HEALTHY	K-7	1980	YES
7	9%	UNDERSTANDING SEXUALITY	9-12	1986	YES
5	7%	HERE'S LOOKING AT YOU 2000	K-9	1986	YES
4	5%	DAIRY COUNCIL-FOOD YOUR CHOICE	K-6	1986	**
4	5%	QUEST SKILLS FOR ADOLESCENCE	7-8	1984	YES
4	5%	REFUSAL SKILLS	1-12	1986	YES
3	4%	HEALTH FOCUS ON YOU	6-8	1983	NO
3	4%	HEALTH FOR LIFE	K-8	1987	NO
2	3%	ALCOHOL, DRUGS DRIVING & YOU	9-10	1986	*
2	3%	MAKING HEALTH DECISIONS	5-8	1985	NO
2	3%	ME- OLOGY	K-6	1985	YES

*One district replied yes to required inservice training, one district replied no.
** Two districts replied yes to required inservice training, and two districts replied no.

Discussion - Growing Healthy is a nationally validated comprehensive health education program. Teenage Health Teaching Modules (THTM) is currently being evaluated nationally.

5. Health Education Instruction Requirements

District contacts were asked to indicate whether health instruction is required for all students at some point, is an elective, is provided at the discretion of individual teachers, or is not offered. As shown in Figure 4, nearly two-thirds of the respondent school districts require health education at some level; it is required least often at the high school level, where it frequently is an elective. Health education is most often seen as a teacher option in the elementary grades, despite the fact that a formal health education curriculum is more likely to be present in districts at those grade levels.

Figure 4

DISTRICT HEALTH EDUCATION INSTRUCTIONAL REQUIREMENTS BY GRADE LEVEL

	Required	Elective	Teacher Option	Not Offered
PRIMARY GRADES	66%	2%	22%	1%
INTERMEDIATE	66%	3%	19%	2%
JUNIOR HIGH/MIDDLE SCHOOL	65%	12%	13%	5%
HIGH SCHOOL	53%	29%	11%	7%

6. Colorado Revised Statutes 22-1-110 (House Bill 1046 - 1985)

Forty-eight (50%) of the districts indicated that they had acquired new materials as a result of the change in Colorado's law in 1985. This law required school districts to offer instruction relating to drug and alcohol abuse. Each district apparently determined its unique needs and chose instructional materials accordingly. Many of the materials acquired are listed in Figure 3.

7. Prevention and Intervention Programs

Prevention and intervention programs that are reportedly in place in the districts are listed in Appendix C.

8. Funding for Health Education

District contacts were asked to identify revenue sources used specifically for health education. A variety of sources are listed in Appendix D. Budget cuts affected 23% of the districts adversely last year by reducing their ability to purchase materials, obtain and keep qualified personnel, and provide inservice training. The district respondents reported that budget cuts diminished the ability of districts to provide health education curriculum to their students. Asked where additional funds would be most useful if they became avail-

able, the district contacts indicated the need for more or improved materials, and inservice training. These two categories were cited twice as often as any other; these same two categories were also chosen most often in surveys conducted in 1975-76 and 1980-81.

9. Community Involvement

Forty-two of the districts indicated that they have surveyed parents and other members of the community to learn what they wish to have included in the school health program. Thirty-four percent of the districts have an active health education committee that involves the community. Of the districts that have such a committee, membership is dominated by school personnel. Parents and local health officials were most often the community members; involvement by students, service organizations, law enforcement officers, representatives of business and labor, religious groups and senior citizens is at a low level.

District contacts were asked how they keep parents and other community members up-to-date about school health education. Responses were placed in three categories: community organization activities, school functions and the media. Community organization activities included citizen review committees, a health education advisory group, open forums and district accountability committees. These are described in Appendix E.

School functions included open houses for parents with the purpose of presenting health education materials, reviewing curriculum guides, and helping evaluate sample texts and videos. Parent-teacher conferences, workshops and special programs conducted by the school nurse contributed to parent education. Health fairs for students and community members were held, and speakers made presentations at meetings of clubs and community organizations. The media efforts undertaken by the districts are described in Appendix E, and include newspaper articles, booklets and brochures, teacher and principal newsletters and school newspapers.

CHAPTER TWO: TEACHER RESPONSES

Part Two of the Survey

Of the 700 Teacher Surveys returned, 540 came from teachers who indicate they provide instruction in Comprehensive Health Education. Of these, 280 were elementary teachers, 113 were junior high/middle school teachers and 112 were high school teachers. A total of 107 respondents could not be easily classified into one of the previous categories and were assigned to the most likely category by the researcher. The results reported in this chapter are based upon these 540 responses.

1. Instructional Time

Respondents were asked to estimate the amount of health education time they provide in each class they teach. The number of teachers who responded at each grade level and the amount of time spent on health education are shown in Figure 5. The range of instructional time varies from approximately 35 hours of health education in the primary grades to 18 weeks of daily health instruction at the senior high level. When one considers the time provided in other academic areas and compare it with the time spent on health instruction, health education is receiving minimal attention.

Figure 5

Average Health Education Instructional Time in Hours Provided by Teachers

Grade Levels	Average Hours Per Year	Number of Teachers Who Responded
1-3	30	61
4-5	39	67
7-9	56	124
10-12	73	75

Research indicates that it takes 50 hours of classroom instruction to affect changes in health knowledge, attitudes and behaviors. In view of the quantity of health education reported here, it is doubtful that many schools are influencing behavior with instructionally-delivered health education.

2. Instruction by Health Content and Health Skill Areas

Teachers were asked to identify the grade level(s) at which they provide instruction in health content and skill areas. Figure 6 shows the amount of instruction provided in specific content areas at grade levels.

Figure 6

Percentage of Teachers Providing Instruction by Grade Levels in Fifteen Content Areas

	Primary	Intermediate	Junior H.S.	High School
AIDS Education	2 %	13 %	52 %	45 %
Alcohol and Other Drugs	28 %	30 %	60 %	47 %
Injury Prevention	35 %	22 %	40 %	32 %
Consumer Health	6 %	8 %	28 %	27 %
Dental Health	43 %	16 %	21 %	15 %
Environmental Health	20 %	16 %	24 %	25 %
Family Life/Human Sexuality Education	5 %	21 %	47 %	41 %
Growth/Development	23 %	23 %	47 %	34 %
Mental Health	12 %	14 %	45 %	39 %
Nutrition	44 %	25 %	44 %	41 %
Personal Health and Fitness	41 %	25 %	50 %	44 %
Disease Prevention	31 %	15 %	37 %	34 %
Sexual Diseases	0 %	7 %	46 %	43 %
Tobacco/Smoking	23 %	28 %	55 %	43 %
Violence/Abuse	11 %	10 %	34 %	30 %

The percent of instruction shows an increasing emphasis on AIDS education and sexually transmitted diseases through the higher grade levels. On the other hand, disease prevention, after the primary level, remains relatively unemphasized. Despite media and school attention to problems of student stress and suicide, instructional time on this content is modest. Personal health/fitness is emphasized throughout the grade levels, probably reflecting the background and knowledge area of a majority of the teachers.

Family life education shows a sharp rise through the grade levels and includes sexuality education; however, many students who would benefit from this area of emphasis need to have early, reinforced training throughout all grade levels. For example, in urban areas, the minority dropout rates minimize exposure to this content in critical years.

Little emphasis is placed on sexual and child abuse and family violence throughout the grade levels. Respondent teachers need more training in this area. Sexual and child abuse and neglect, as well as family violence, are certain indicators of children at risk not only for poor academic achievement, but also for eating disorders, drug and tobacco abuse, emotional problems, teenage pregnancy, violence toward others, school dropout, criminal offenses and poor employment potential. These are also persons who will behave in similar ways toward their spouses and children. Evidence is clear that health education can contribute to reversing these proclivities.

Dental and environmental health emphases drop over the grade levels. Colorado has persistently ranked poorly in terms of the dental health of its population. Perhaps involving

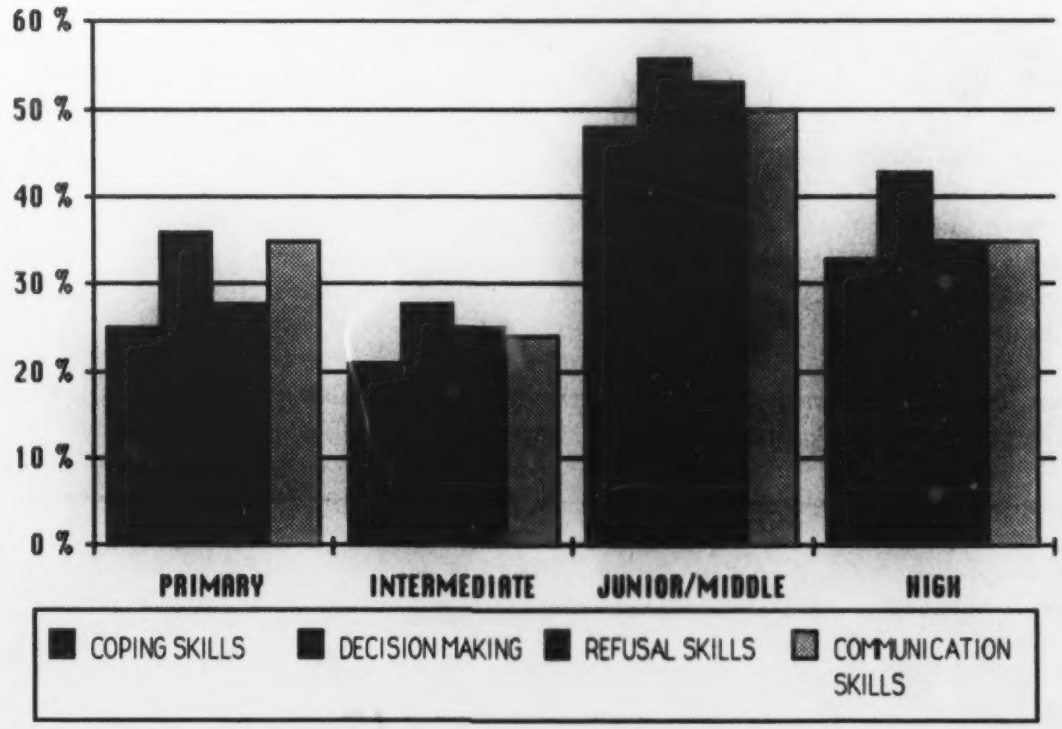
the School of Dentistry in school programs during junior and senior high school years would be helpful.

Finally, the rankings show a rather consistent emphasis, after the primary years, on drug and tobacco education. Again, the lack of primary school emphasis in this area runs contrary to research on effective health education. Evidence demonstrates that the earlier the education, the more effective the behavioral intervention. In fact, the most recent evidence shows clear, positive correlations between the number of years of health education on the one hand, and knowledge and desirable behaviors on the other. Students with three or more years of health education are much more likely than their cohorts with less health education to abstain from tobacco and drug use, to make changes to improve their health, to express a feeling of control over their health and to exercise regularly.

Figure 7 shows the percent of health skills by grade level. These skills enable students to resist peer pressure, develop relationships, actualize independence and develop strong decision-making capabilities. The emphasis is invariant. Decision-making is at first rank regardless of grade level, and coping skills are ranked fourth. This may be reflective of the emphasis upon decision-making in drug and sexuality education, as well as the relative lack of attention given to mental health, abuse and violence.

Figure 7

Percentages of Teachers Providing Instruction in Four Health Skill Areas



3. The most Important Major Health Content and Skill Areas

Teachers were asked to prioritize three of the 15 health content areas and two of the four health skill areas. Education about alcohol and other drugs was listed as one of the health content priority areas by 50% of the teachers. As shown in Figure 8, when asked what in-service training would be helpful to them, the teachers most frequently identified mental health education, AIDS education, and coping skills education as their top three interests. However, priorities were different for teachers depending on where (geographically) they teach.

The priority areas are interesting when compared to provision of instruction summarized in Figures 6 and 7. For example, Coping Skills are the least provided health skill area and teachers — perhaps recognizing this as a deficit — rank it rather high as a priority for training. The high ranking of Mental Health may indicate a similar concern by teachers, who currently provide relatively little instruction in this area.

Figure 8

Ranking of Health Content Priority Areas for Inservice by School District Setting

Health Content Areas	School District Setting			
	Outlying	Rural	Suburban City	Urban
Abuse/Violence	8	9	7	5
AIDS Education	2	2	4	4
Alcohol and Other Drugs	5	5	2	3
Communication Skills	9	8	8	6
Coping Skills	3	3	5	2
Decision making	6	7	6	9
Family Life/Human Sexuality	7	4	9	8
Mental Health	1	1	1	1
Refusal Skills	4	6	3	7

Note: These are the nine most frequently mentioned health content and skill areas from the 19 identified in Figures 6 and 7.

4. Instructional Resources

The teachers surveyed were asked what resources they used in teaching health education. They reported that district curriculum was the most-used such resource, followed by curriculum developed by other schools. Information and/or speakers ranked high by teachers as resources were:

- the Dairy Council;
- local law enforcement agencies;
- local hospital or medical personnel;
- the Lung Association;
- the Cancer Society;
- the local health department;
- the Colorado Department of Education's Health Education Program;
- the Colorado Department of Health; and
- the Heart Association.

Cited as being used less frequently were resources from:

- the Area Health Education Councils (AHEC);
- Mile High Council on Alcoholism;
- Kaiser Permanente's *Professor Bodywise*;
- the Rocky Mountain Center for Health Promotion and Education;
- the Prevention Center;
- *Adolescent Health in Colorado,* document; and
- the Hall of Life, Denver Museum of Natural History.

It is interesting to note that although the Rocky Mountain Center for Health Promotion and Education was cited by teachers as a less frequently used resource, in actuality (as reported in Chapter 1), the curriculum packages disseminated by the Center are the most used in the state. This might reflect that teachers know the name of curriculum, Teenage Health Teaching Modules (THTM) and Growing Healthy , but are not familar with the organization providing the materials.

CHAPTER THREE: ENDORSEMENTS AND POLICIES

1. Areas of Certification of Teachers and District Contacts

The Teacher Survey revealed that 77% of the respondents are currently providing instruction in health education. As shown in Figure 9, 20% of these are certified in health education, 32% are certified in health and physical education, and 40% are certified to teach elementary education. Other teachers who are most frequently charged with teaching health education are those certified in the sciences, physical education, home economics, nursing, biology and counseling.

District contacts were also asked to identify their area of certification. Of the 96 who responded, 12% are certified in health education. The data indicate that a lower percentage of district contacts are certified in health education than are the teachers who responded to the survey. One in three are certified in health and physical education. Twenty-one percent are certified in the area of administration. In many districts, the health education contact is the curriculum coordinator, principal or superintendent, and would likely be certified in a variety of subject areas.

Of the 20% of **teachers** who responded that they are certified in health education, half teach in a district with more than 6,000 students, 36% teach in a district with between 601 and 6,000 students, and 12% teach in a district with 600 or fewer students. Of the 12% of **district contacts** with certification in health education who responded, 23% work in districts with over 6,000 students, 44% work in districts with a student population between 601 and 6,000, and 33% are employed in districts having 600 or fewer students.

In Colorado and many other states, persons certified in physical education before 1975 also were certified in health education with little course work in the area. The assumption that many survey respondents received their degree prior to 1975 may explain the fact that certified physical educators are the single largest group involved in health education.

Figure 9

Certification Areas of Teacher and District Contact Respondents

Certification Area*	Teacher Respondents	District Contact Respondents
Health Education	20	12
Health and Physical Education	32	33
Elementary Education	40	12
Administration	--	21
Science	5	6
Physical Education	5	--
Home Economics	5	5
Nursing	5	7
Mathematics	--	7
Biology	3	--
Counseling	2	--
All Others	--	9

* Responses are given in percentages. The base for the Teacher Survey is 700; the base for the District Survey is 96. Total of both columns is more than 100% due to some teachers and some district contacts having certification in more than one area.

2. Formal Health Education Experience

Teachers and district contacts were asked to identify the number of collegiate hours of health courses and health-related inservice contact hours they have completed in the last three years. Teachers reported an average of 15 collegiate hours and nine inservice contact hours. District contacts reported an average of 18 collegiate hours and 21 inservice contact hours.

District health education contacts have completed more collegiate hours and inservice contact hours in a health-related field than the teachers who responded to the survey. Classroom health education instructors report not receiving adequate inservice training to stay abreast of the health information explosion. A great deal of health instruction is taking place without teachers receiving the inservice training they reported they need. And most of the health education instructional materials used in Colorado school districts require teacher inservice training. Results from the teacher survey indicate that teachers are requesting inservice training in mental health, AIDS, coping skills, alcohol and drug abuse and other topics that may not lend themselves to a straightforward, factual approach to learning. In fact, the need for inservice training exists across all content and skill areas.

3. District Health Education Written Policy

Relatively few districts have written health education policies to guide teachers and administrators. This is unfortunate for, if a district does not have a written policy, teachers may be placed in the awkward position of making choices about instruction in sensitive areas. Figure 10 summarizes survey findings in regard to the percentage of reporting districts and their development of comprehensive written health education policies. About 40% of the reporting districts' elementary schools and high schools, and just over 51% of all junior highs/middle schools have a comprehensive written health education policy. Of the districts that do have such written policies, most have written those policies within this decade. Policy development appears strongest in junior high/middle schools.

Figure 10

Percentage of Responding Districts Reporting a Written Health Education Policy By Education Level and Date of Development

	Elementary	Junior High/ Middle School	High School
1970s	13%	11%	10%
1980s	28%	40%	30%
Total with Policies	41%	51%	40%

4. Written District Policies on Specific Health Issues

Figure 11 presents findings about the written health policies of district respondents on specific health issues. For example, 77% of the districts responding indicate that they have a smoking policy for students, and only 41% have such a policy for staff. Half the respondents indicate that their districts have developed a policy regarding persons infected with AIDS, and about one-third indicate that an AIDS education or human sexuality/family life education policy exists.

Figure 11

Percentage of Respondent Districts Reporting Specific Health Issue Policies

Health Issues	Percent	Year Implemented
AIDS Infected Individuals	50%	1984
AIDS District Education Policy	35%	1985
Drug and Alcohol Use	79%	1960
Tobacco Use by Students	77%	1960
Tobacco Use by Staff	41%	1965
Teen Pregnancy	26%	1970
Human Sexuality/Family Life Education	32%	1964

CHAPTER FOUR: CONCLUSION

Health education — taught in Kindergarden through the 12th grade — using validated curricula — by well-trained instructors — versed in a variety of teaching methods — based on student and community needs — has been shown to promote school achievement, community involvement, health enhancing behaviors and prevent premature illness and death. Thus health education is of importance not only to Colorado schools, but to society as a whole. Colorado citizens have a major interest in ensuring that the health education provided to Colorado students is maximally effective.

Health educators and administrators in Colorado public schools face many challenges. As this survey reveals, teachers need additional educational preparation and inservice training. Districts need to develop written health education policies and make better use of existing health education curricula. Parents and members of the community need to be actively involved in planning the health education that will most effectively meet the needs of students in their district. Overall, there is much to be done to improve the situation in regard to health education in Colorado. It is hoped that this study will provide a basis for development of effective health education programming throughout the state.

Appendix A - Part One, The District Survey

1988 Colorado School Health Education Survey
District Health Education Contact Survey

Please return to:

Mary Lou Myers
H. E. Survey Project Director
Colorado Department of Education
201 E. Colfax Ave.
Denver, CO 80203

Date _____
Please check spelling and
make address corrections.

A. Do you have a Colorado teaching endorsement in health education? Yes__ No__
B. Do you have a Colorado teaching endorsement in health and physical education? Yes__ No__
C. If no, what subjects are you endorsed to teach?_____
D. How many collegiate hours of health courses have you completed?_____
E. In the past 3 years, how many inservice contact hours have you completed in a health related field?_____

POLICY

1. Does your district have a written policy concerning health education for the following grade levels? Check those that apply and indicate the year implemented and revised.

Grade Level	Year Implemented	Year Last Revised
_____ (a) elementary	_____	_____
_____ (b) middle school/ junior high	_____	_____
_____ (c) high school	_____	_____

2. Does your district have written policies regarding the following health issues? Check those that apply and indicate the year implemented and revised.

Health Issues	Year Implemented	Year Last Revised
_____(a) AIDS-infected individuals	_____	_____
_____(b) AIDS-district educational policy	_____	_____
_____(c) illicit drug/alcohol use	_____	_____
_____(d) tobacco use by students	_____	_____
_____(e) tobacco use by staff	_____	_____
_____(f) teen pregnancy	_____	_____
_____(g) human sexuality/family life education policy	_____	_____

CURRICULUM

A formal health education curriculum is defined here as:
A written plan containing detailed information regarding grade level offerings and other suggestions for health education instruction in the school district. It describes overall philosophy, goals, objectives, scope and sequence of the health education program.

3. Does your district have in place a formal curriculum for health education? Yes _____ No _____

   3a. If yes, check all grades that are included. If no, skip to #5.

   ___K___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 ___11 ___12

4. What factors influenced the adoption of your curriculum? **(check all that apply)**

   _____(a) Needs assessment
   _____(b) Community input
   _____(c) Student interest
   _____(d) Teacher interest
   _____(e) Teacher training needed
   _____(f) Instructional time
   _____(g) Research on health needs
   _____(h) Research on student needs
   _____(i) Administration interest/direction/support
   _____(j) School Board interest/ direction/support
   _____(k) Cost of Program
   _____(l) Other (specify)_____

5. What curricular materials/instructional packages have been adopted, purchased, or developed?

Name curricular materials/instructional packages	Grade In Which Used	Year Implemented
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____

6. Have district personnel received inservice training in the curricular materials/ instructional packages listed in question #5? Yes___ No___

   6a. If yes, list the curricular materials around which inservice training was provided?

   _____

   _____

   _____

   _____

7. At each grade level, indicate whether health instruction is: (A) required for all students at some point, (B) is an elective available to the students, (C) is provided at the discretion of individual teachers, or (D) is not offered.

	A Required	B Elective	C Teacher Option	D Not Offered
I. Primary Grades	_____	_____	_____	_____
II. Intermediate	_____	_____	_____	_____
III. Jr.Hi/Middle School	_____	_____	_____	_____
IV. High School	_____	_____	_____	_____

8. Did your district acquire new materials in response to Colorado revised statute 22-1-110, CONCERNING PUBLIC SCHOOL INSTRUCTION ABOUT THE EFFECTS OF THE USE OF ALCOHOLIC DRINKS AND CONTROLLED SUBSTANCES? Yes___ No___

8a. If yes, please describe materials selected._____

_____

_____

PROGRAMS

9. Are any of the following prevention, intervention programs in place in your district? If yes, check the name of program(s).

_____ (a) Student Assistance
_____ (b) Peer Counseling
_____ (c) Alternative activities
_____ (d) On site health/mental health services
_____ (e) Parent education programs
_____ (f) Mentor programs
_____ (g) Wellness program for staff and/or students (e.g. smoking cessation and fitness)
_____ (h) Other (specify) _____
(i) Please identify program(s) by name, (e.g.Top Teens, High on Life)._____

_____

_____

FUNDING

10. Identify revenue sources you receive specifically for Health Education._____

_____

_____

11. Have district budget cuts adversely affected your health education program? Yes___ No___

11a. If yes, in what way_____

_____

12. If there were additional funds available for health education programming where would such funds be of greatest assistance? **(Check no more than three)**

_____ (a) Increased staffing
_____ (b) Inservice training
_____ (c) New equipment
_____ (d) More or improved materials
_____ (e) Extracurricular programs (e.g. Top Teens)
_____ (f) Development of district health education curriculum
_____ (g) Adoption of exemplary health education curriculum
_____ (h) Evaluation
_____ (i) Field trips, (e.g. Hall of Life)
_____ (j) Resource people (e.g. consultants, guest speakers)
_____ (k) Health fairs
_____ (l) Subscribing to newsletters, periodicals, and/or journals
_____ (m) Other (specify)_____

COMMUNITY INVOLVEMENT

13. Have parents and other community members been surveyed to see what they would like included in a school health education? Yes___ No___

14. By what means do you keep parents up to date regarding health education?
Describe_____

_____

_____

15. Do you have an active community/school health education committee? Yes___ No___

15a. If so, who is included on the committee? **(Check all that apply)**
_____teachers _____parents _____students _____principal
_____district administration _____law enforcement _____local health officials
_____business/labor _____service and civic organizations
_____religious groups _____senior citizens _____other (specify)_____

16. Is there a resource list of community health related organizations, agencies, or individuals available to teachers. Yes___ No___

17. Are you willing to share policies and needs assessment /results/ instruments developed by your school district with others in the field? Yes___ No___

Thank you for your help. The results will be sent to you.
IF YOU HAVE ANY QUESTIONS, PLEASE CALL MARY LOU MYERS 866-6767

Appendix B - Part Two, The Teacher Survey

1988 Colorado School Health Education Survey
Health Education Instructor Survey

Return to:
Mary Lou Myers
HE Survey Project Director
State Office Building
201 E. Colfax Avenue
Denver, CO 80203

Your Name_____ Date_____

County_____ District number_____

School(s) where you work_____

Grade level(s) you teach_____ Your title_____

A. Do you have a Colorado teaching endorsement in health education? Yes__ No__

B. Do you have a Colorado teaching endorsement in health and physical education? Yes__ No__

C. If no, what subjects are you endorsed to teach? _____

D. How many collegiate hours of health courses have you completed?_____

E. In the past 3 years, how many inservice contact hours have you completed in a health related field?____

Comprehensive Health Education may include the following content areas:
AIDS Education, Alcohol and other Drugs, Accident/Injury Prevention, Safety and First Aid, Consumer Health, Dental Health, Family Life/Human Sexuality Education, Growth and Development, Mental Health/Stress, Nutrition, Personal Health and Fitness, and Prevention and Control of Disease.

Comprehensive Health Education may include the following skill areas:
Coping, decision making, refusal, and communication skills.

Do you provide instruction in any of the above content or skill areas? Yes___ No___

If Yes, continue. If No, stop and return the survey in the enclosed envelope.

1. Identify the grade level(s) at which you provide instruction in the CONTENT AREAS listed below. (Check all that apply.)

CONTENT AREAS	K	1	2	3	4	5	6	7	8	9	10	11	12
(a) AIDS Education													
(b) Alcohol and Other Drugs													
(c) Accident/Injuiry Prevention, Safety, First Aid, CPR, Survival Skills													
(d) Consumer Health													
(e) Dental Health													
(f) Environmental Health													
(g) Family Life/Human Sexuality Education													
(h) Growth/Development													
(i) Mental Health, Stress, Suicide Prevention													
(j) Nutrition													
(k) Personal Health and Fitness													
(l) Prevention and Control of Disease													
(m) Sexually Transmitted Diseases													
(n) Tobacco/Smoking													
(o) Violence, Homocide, Child Abuse/Neglect, Sexual Abuse													
(p) Other (Describe)													

2. Identify the grade level(s) at which you provide instruction in the following **SKILLS**. (Check all that apply)

SKILL	K	1	2	3	4	5	6	7	8	9	10	11	12
(q) Coping Skills													
(r) Decision Making													
(s) Refusal Skills													
(t) Communication Skills													
(u) Other, (describe)													

3. Please, describe the amount of time you are providing Health Education in <u>each</u> class you teach? (e.g. third grade, full year, three times per week for 50 minutes)

_____

_____

4. For the students you teach, prioritize the 3 **content** areas that you believe are most importa

(a)_____(b) _____(c) _____

5. For the students you teach, prioritize the 2 **skill** areas that you believe are most important.

(a) _____(b) _____(c) _____

6. In which health education content/skill areas would you like additional inservice training?
(a) _____ (b) _____(c) _____

7. Which of the following resources do you use in teaching health?
(Check all that apply)

____(a) BOCES
____(b) Area Health Education Council (AHEC)
____(c) Local health department
____(d) Local hospital or medical personnel
____(e) Dairy Council
____(f) Lung Association
____(g) District curricular materials
____(h) Prevention Center
____(i) Other school curriculum
____(j) Colorado Department of Education, Health Education Program
____(k) Colorado Department of Health
____(l) Rocky Mountain Center for Health Promotion and Education
____(m) Local law enforcement
____(n) Heart Association
____(o) Cancer Association
____(p) Hall of Life
____(q) Kaiser - Professor Bodywise
____(r) Colorado Department of Education, Child Nutrition Unit
____(s) Mile High Council on Alcoholism
____(t) ADOLESCENT HEALTH IN COLORADO document
____(u) Other, Please Specify_____

8. Please complete the following matrix by inserting the title of books, films, videos, computer programs etc. you have **used with** students and would **recommend** to others.

CONTENT AREAS	Complete Title	Recommended Grade Level	Film Strip	Video	Film	Computer Software
(a) AIDS Education						
(b) Alcohol and Other Drugs						
(c) Accident/Injury Prevention, Safety, First Aid,CPR, Survival Skills						
(d) Consumer Health						
(e) Dental Health						
(f) Environmental Health						
(g) Family Life/Human Sexuality Education						
(h) Growth/Development						
(i) Mental Health Stress, Suicide Prevention						
(j) Nutrition						
(k) Personal Health and Fitness						
(l) Prevention and Control of Disease						

CONTENT AREAS	Complete Title	Recommended Grade Level	Film Strip	Video	Film	Computer Software
(m) Sexually Transmitted Diseases						
(n) Tobacco/Smoking						
(o) Violence, Homocide, Child Abuse/Neglect, Sexual Abuse						
(p) Other Please Describe						
SKILL AREAS						
(q) Coping Skills						
(r) Decision Making						
(s) Refusal Skills						
(t) Communication Skills						
(u) Other, (describe)						

Thank-you very much for your cooperation. If you have questions call Mary Lou Myers at 866-6767.

Please send the completed survey by March 15, 1988.

Appendix C - Prevention and Intervention Programs in Place in Responding Districts

PREVENTION AND INTERVENTION PROGRAM IDENTIFIED BY NAME

Student Assistance:
TOUGH LOVE, IMPACT, SAP

Peer Counseling:
Partners, Bionic, TNT-Teens Needing Teens, Youth to Youth Training, Student to Student

Alternative Activities:
STAND/SADD, All Stars, "A Team," Youth to Youth, Reach

Health/Mental Health Services:
School health services - Aspen Valley Hospital, Dolores County Nursing Service, Elbert County health nurse, Centennial Mental Health, school based clinics.

Parent Education Programs:
Tough Love, Mothers Against Drunk Driving (MADD), Talking With Your Kids About Alcohol (TWYKAA), Parent action committee, Drug Free School - Parent/Teacher club, STEP, Aware, Choices and Challenges.

Mentor Programs:
SAPP - Substance Abuse Prevention Program, Partners.

Wellness Programs (staff and students):
Health Sense (staff), Why Weight, American Cancer Society (Stop Smoking), Building Challenge for Staff Fitness, Slim for Life.

Appendix D - Revenue Sources Reported Used for Health Education

Health Education Revenue Sources as Listed By District Contacts

District contacts were asked to identify revenue sources and additional funds used specifically for health education. We have indicated all of the revenue sources exactly as they were listed on the returned questionnaire. This information is provided as a resource to those district contacts searching for potential health education funding sources.

Chapter 2 Grant
school budget
local funds
ADEPT grant
health budget
local tax base
Postitive Action
CDC AIDS Education grant
general fund budget
state funds
Communities for Drug Free Colorado
Current Inc. for AIDS education
physical education/health budget
Department of Health - Drug and Alcohol Prevention
school health curriculum project
Denver Broncos Youth Foundation
district funds
capitol reserve
CDE grant monies
school board
Science Foundation
building level funds
curriculum service
Omnibus Grant

Appendix E - Ways that Districts Inform Parents and Other Community Members About Health Education

COMMUNITY INVOLVEMENT

Fourty four percent of the districts indicated that they had surveyed parents and other community members regarding what they would like included in the school health education provided to students in their community.

District contacts were asked to identify methods by which they keep parents up-to-date regarding school health education. Responses were placed in three categories: Community Organization Activities, School Functions, and Media.

Community Organization Activities

- district accountability committee
- school board meetings
- health task force
- health education advisory group
- open forum
- PTA presentations
- church education program
- parent advisory committee, PTA, PTO
- citizen review committees
- partners in parenting
- steering committee
- DARE group involved in district's schools
- ministerial alliance

School Functions

Open houses were held for parents with the purpose of presenting health and sexuality education materials, reviewing curriculum guides, and assisting in the evaluation of sample text books and videos. Curriculum was developed with help from parents in the community during health curriculum meetings. Parent teacher conferences, workshops, classes, and special programs provided by the school nurse contributed to education of parents. Health Fairs for students and community members were held and informal speakers at clubs presented information.

Media

- teacher newsletters
- principal newsletters
- local newspaper
- news media
- surveys
- public reports to the school board
- school newspaper
- newspaper articles
- accountability newspaper
- booklets / brochures
- accountability reports

Thirty-four percent of the districts stated that they had an active community/school health education committee. Parents, teachers, principals, district administration and local health officials were indicated most often as committee members. Membership by religious groups, students, service organizations, law enforcement, business/labor representatives, and senior citizens was reported as minimal.

Appendix F - School Districts Listed by Size and Setting

SETTING: URBAN
SIZE: OVER 25,000
Denver 1 Denver
El Paso 11 Colorado Springs
Jefferson R-1 Jefferson

SETTING: URBAN
SIZE: 6,001-25,000
Boulder Re1J St. Vrain Valley
Boulder Re-2(J) Boulder Valley
Larimer R-1 Poudre (Fort Collins)
Larimer R-2J Thompson
Mesa 51 Mesa County Valley
Pueblo 60 Pueblo City
Weld 6 Greeley

SETTING: SUBURBAN
SIZE: 6,001-25,000
Adams 12 Northglenn-Thornton
Adams 50 Westminster
Arapahoe 5 Cherry Creek
Arapahoe 6 Littleton
Arapahoe 28J Aurora
Douglas Re1(J) Douglas County
El Paso 2 Harrison
El Paso 3 Widefield
El Paso 20 Academy

SETTING: SUBURBAN
SIZE: 1,201-6,000
Adams 1 Mapleton
Adams 14 Adams City/Commerce City
Arapahoe 1 Englewood
Arapahoe 2 Sheridan
El Paso 12 Cheyenne Mountain
El Paso 38 Lewis-Palmer
El Paso 49 Falcon
Pueblo 70 Pueblo County Rural

SETTING: SUBURBAN
SIZE: 601-1,200
El Paso 14 Manitou Springs

SETTING: OUTLYING CITY
SIZE: 1,201-6,000
Adams 27J Brighton
Alamosa Re11J Alamosa
Delta 50(J) Delta County
El Paso 8 Fountain
Fremont Re-1 Canon City
Fremont Re-2(J) Florence
Garfield Re1(J) Roaring Fork
Garfield Re2 Garfield
Gunnison Re1J Gunnison
La Plata 9-R Durango
Las Animas 1 Trinidad
Logan Re-1 Valley (Sterling)
Moffat Re: No. 1 Moffat
Montezuma Re-1 Cortez
Montrose Re-1J Montrose County
Morgan Re-3 Fort Morgan
Otero R-1 East Otero
Otero R-2 Rocky Ford
Prowers Re-2 Lamar
Rio Grande C-8 Monte Vista
Routt Re-2 Steamboat Springs
Summit Re1 Summmit
Weld Re-1 Gilcrest
Weld Re-4 Windsor
Weld Re-8 Fort Lupton

SETTING: OUTLYING CITY
SIZE: 601-1,200
Bent Re1 Las Animas
Chaffee R-31 Buena Vista
Chaffee R-32 Salida
Huerfano Re-1 Huerfano
Kit Carson Re-6J Burlington
Morgan Re-2(J) Brush
Pitkin 1 Aspen
Weld Re-2 Eaton
Weld Re-5J Johnstown-Milliken

SETTING: RURAL MOUNTAINOUS
SIZE: 1,201-6,000
Clear Creek Re-1 Clear Creek
Eagle Re50(J) Eagle County
Lake R-1 Lake County
Teller Re-2 Woodland Park

SETTING: RURAL MOUNTAINOUS
SIZE: 601-1,200
Archuleta 50Jt Pagosa Springs
Grand 2 East Grand
Larimer R-2(J) Park (Estes Park)
Park 1 Platte Canyon

SETTING: RURAL MOUNTAINOUS
SIZE: 301-600
Gilpin Re-1 Gilpin County
Grand 1(Jt) West Grand
Jackson R-1 North Park
Mesa 50 Plateau Valley
Park Re-2 Park County
Teller Re1 Cripple Creek-Victor

SETTING: RURAL MOUNTAINOUS
SIZE: 300 AND LESS
Hinsdale Re 1 Hinsdale County
Huerfano Re-2 La Veta
Mineral 1 Creede
Ouray R-1 Ouray
Ouray R-2 Ridgway
San Juan 1 Silverton
San MIguel R-1 Telluride

SETTING: RURAL AGRICULTURAL
SIZE: 601-1,200
Adams 29J Bennett
Conejos Re-1J North Conejos
Elbert C-1 Elizabeth
La Plata 10Jt-R Bayfield
La Plata 11Jt Ignacio
Rio Blanco Re1 Meekjer
Rio Blanco Re4 Rangely
Rio Grande C-7 Del Norte
Weld Re-3(J) Keenesburg
Weld Re-7 Platte Valley
Weld Re-9 Ault-Highland
Yuma RJ-1 West Yuma County
Yuma RJ-2 East Yuma County

SETTING: RURAL AGRICULTURAL
SIZE: 301-600
Adams 31J Strasburg
Arapahoe 32J Byers
Baca Re-1 Walsh
Baca Re-4 Springfield
Conejos 6J Sanford
Conejos Re-10 South Conejos
Costilla R-1 Centennial
Crowley Re-1-J Crowley
Dolores Re No. 1 Dolores County
El Paso RJ-1 Calhan
El Paso 22 Ellicott
Garfield 16 Parachute
Lincoln Re-4J Limon
Montezuma Re-4A Dolores
Montezuma Re-6 Mancos
Montrose Re-2 West End
Morgan Re-50(J) Wiggins
Otero R-4J Fowler

Phillips Re-1J Holyoke
Prowers Re-3 Holly
Rio Grande Re-33J Sargent
Routt Re-1 Hayden
Routt Re3(J) South Routt
Saguache 26Jt Center
San Miguel R-2J Norwood
Sedgwick Re-1 Julesburg
Washington R-1 Akron

SETTING:
RURAL AGRICULTURAL
SIZE: 300 AND LESS
Alamosa Re-22J Sangre de Cristo
Arapahoe 26J Deer Trail
Baca Re-3 Pritchett
Baca Re-5 Vilas
Baca Re-6 Campo
Bent Re-2 McClave
Cheyenne R-1 Kit Carson
Cheyenne R-5 Cheyenne County
Costilla R-30 Sierra Grande
Custer C-1 Consolidated
Elbert C-2 Kiowa
Elbert 100(J) Big Sandy
Elbert 200 Elbert
Elbert 300 Agate
El Paso 23Jt Peyton
El; Paso 28 Hanover
El Paso 54Jt Edison
El Paso 60Jt Miami-Yoder
Fremont Re-3 Cotopaxi
Kiowa Re-1 Eads
Kiowa Re-2 Plainview
Kit Carson R-20 Arriba-Flagler
Kit Carson R-23 Hi-Plains
Kit Carson R-4 Stratton
Kit Carson R-5 Bethune
Las Animas 2 Primero
Las Animas 3 Hoehne
Las Animas 6 Aguilar
Las Animas 82 Brandon
Las Animas 88 Kim
Lincoln C113 Genoa-Hugo
Lincoln Re-23 Karval
Logan Re-3 Frenchman
Logan Re-4(J) Buffalo
Logan Re-5 Plateau
Mesa 49Jt De Beque
Morgan Re-20(J) Weldon Valley
Otero 3J Manzanola
Otero 31 Cheraw
Otero 33 Swink
Phillips Re-2J Haxtun
Prowers Re-1 Granada
Prowers Re-13Jt Wiley
Saguache Re1 Mountain Valley
Saguache 2 Moffat
San Iguel 18 Egnar
Sedgwick Re-3 Platte Valley
Washington R-2 Arickaree
Washington R-3 Otis
Washington 101 Lone Star
Washington 104 Wodlin
Weld Re-10(J) Briggsdale
Weld Re-11(J) Prairie
Weld Re-12 Grover

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1989

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